

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton P.D.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Rural Elkton P.D.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. RD 3

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Anderson

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mary Anderson

6. (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov 20 1864

8. AGE: 82 Years 7 Months 21 Days If less than one day hrs. min.

9. Birthplace Cecil Co Md  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Charles Anderson

13. Birthplace New Richmond

14. Maiden name Nancy Dewey

15. Birthplace New Richmond

16. Informant Mrs. Bertha M. Chaswell

Address Elkton Md P.D.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Feb 14 1946 (month) (day) (year)

Cemetery or crematory Head of Christiana

Location Near Milwark Del

18. Funeral director R. J. Jones

Address Milwark Del

19. July 13 1946 FR Frazer

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mg 19 1946, July 11 1946

and that I last saw him alive on July 11 1946

Immediate cause of death

Bronchitis Pneumonia DURATION 3 days

Due to

Due to

Other conditions Fractured Femur 4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Mg 30

Accident, suicide, or homicide Date of

Where did injury occur? Ct. Harw (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury fell out of bed Injured at work? No

23. SIGNATURE R. J. Jones

Address 16 W. Main Date signed 7/14/46

RECEIVED  
JUL 18 1946  
BUREAU VER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

06908

CHANGE OF AGE: Letter filmed

2411 N. Charles St., Baltimore 93-2

July 8 1946 G 104 LL (Dr. Trol-CERTIFICATE OF DEATH  
linger's letter)

Reg. Diat. No. 96

1. PLACE OF DEATH:  
County..... Cecil  
City or town..... Veterans Administration Perry Point, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 3 yrs. 12 days  
Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
How long in hospital or institution?..... Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County.....  
City or town..... 2018 Ellsworth Street, Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 2018 Ellsworth Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... WW I

3. (a) FULL NAME  
APPLEGATE, John

3. (b) Social Security Number

4. Sex..... Male  
5. Color or race..... White  
6. (a) Single, married, widowed, or divorced..... Married  
6. (b) Name of husband or wife..... Ethel Marie Bremont  
6. (c) If alive, give age..... 43 years  
7. Birth date of deceased (mo., day, yr.)..... December 28, 1890// 1893

8. AGE: Year..... 52 55/ Months..... 6 Days..... 3 It less than one day..... hrs. .... min.

9. Birthplace..... Tombs Run, Pa.  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... John Applegate  
13. Birthplace..... Pennsylvania

14. Maiden name..... Clara McPherson  
15. Birthplace..... Pennsylvania

16. Informant..... Hospital Records  
Address..... Veterans Administration, Perry Point

17. Removal..... Date thereof..... July 2, 1946 Md.  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Baltimore Cemetery  
Location..... Baltimore, Md.

18. Funeral director..... Albert E. Holtz  
Address..... Baltimore, Md.

19. Date rec'd by registrar..... July 2, 1946 June 8 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 2 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 19 1943 to July 2 1946  
and that I last saw him alive on July 2 1946

Immediate cause of death.....  
Myocardial insufficiency, due to  
myocardial damage, arteriosclerosis  
// coronary Over 2 yrs.

Due to.....  
Due to.....

Other conditions..... Psychosis with cerebral  
arteriosclerosis Over 2 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... Not performed  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury..... Injured at work? .....

23. SIGNATURE.....  
A.E. TROLLINGER, M.D. Clinical Director  
Veterans Administration, Perry Point, Maryland.  
Date signed..... 7-2-46

RECEIVED  
JUL 5 1946  
BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

## CERTIFICATE OF DEATH

06909

Reg. Dist. No. 94

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... North East (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 year  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... North East (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Henry F Atkinson

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Gentude Atkinson

7. Birth date of deceased (mo., day, yr.)

July 14 1864

8.(c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
81	11	18	
			hrs. min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Stationary Engineer

11. Industry or business

MOTHER FATHER

12. Name

Elisha Atkinson

13. Birthplace

Maryland

14. Maiden name

Isabella Heath

15. Birthplace

Maryland

16. Informant

Elisha Atkinson, Jr.  
North East (Rural) Md

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof July 5 1946  
(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Md

18. Funeral director

Joseph R. Grant

Address

North East Md

19. July 5 1946

Lida R. Evans  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to July 2 1946  
and that I last saw him alive on July 1 1946

Immediate cause of death

Angina Pectoris

DURATION

2 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

O. B. Collins

M. D. or other

Address North East, Md. Date signed 7-5-46

20032

RECEIVED  
JUL 9 1946  
BUREAU V K

ARTESIAN FORER

NO CONTENT

30-

## Reg. Diat. No. .... 96

(Date rec'd by registrar) \_\_\_\_\_ Registrar \_\_\_\_\_

VS A15

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RECEIVED  
JUL 17 1946  
BUREAU V K

cc Keenan



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County.....*Cecil*  
 City or town.....*Bambridge Md. Bambridgeville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*Lived there since 9/18/45*  
 Hospital, institution, or street address where death occurred:  
*Found dead Bldg 905. Pronounced dead Bldg 617 Dispensary.*  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....*Md* County.....*Cecil*  
 City or town.....*Bambridge Village Bambridge Md.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

*Earle Miller Beaverson*

## 3. (b) Social Security Number

4. Sex.....*Male* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Single*

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....*29 Aug 1890*

8. AGE: Years.....*55* Months.....*9* Days.....*17* If less than one day..... hrs. .... min.

9. Birthplace.....*York, Pa.*  
(Town, county, and state)10. Usual occupation.....*Civilian Patrolman*11. Industry or business.....*Enpl. USA Training Center*12. Name.....*Edwin S. Beaverson*13. Birthplace.....*York Co. Pa.*14. Maiden name.....*Bertha Miller*15. Birthplace.....*York Co. Pa.*16. Informant.....*Harold R. Beaverson.*Address.....*R. D. #7, York Pa.*17. Burial.....*Burial* Date thereof.....*July 20, 1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....*Mt. Zion*Location.....*York, York Co. Pa.*18. Funeral director.....*W. A. Patterson & Son*Address.....*Perryville, Md.*19. Date rec'd by registrar.....*July 18, 1946* Registrar.....*James E. Doughty*

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*15 July* 19..*46* at..*9:25 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....*Coronary thrombosis and myocardial infarction* DURATION.....*6 hours*Due to.....*Arteriosclerosis and hypertensive heart disease* UnknownDue to.....*Nephrosclerosis, benign Fibrous pleuritis*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....*above 15 July 46 US Naval Hospital*PHYSICIAN: Please underline the cause to which death should be charged statistically.  
*Bambridge Md.*

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?.....

Means of injury..... Injured at work?.....

Medical Examiner.....

23. SIGNATURE.....*Blair Dodson* for Cecil County

M. D. or other.....

Address.....*Blair Dodson* Date signed.....*7-15-46*

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JUL 22 1946

BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

 (5) 06912 94  
 Reg. Dist. No.

## 1. PLACE OF DEATH:

County Cecil

City or town North East  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Victor H Benjamin

## 3. (b) Social Security Number

218-18-5900

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Alvin V Benjamin

## 7. Birth date of deceased (mo., day, yr.)

Dec. 8 1878

## 6. (c) If alive, give age years

65

## 8. AGE:

Years 67 Months 7 Days 11 hrs. min.

## 9. Birthplace

North East, Cecil Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Carpenter

## 11. Industry or business

William W Benjamin

## 13. Birthplace

Maryland

## 14. Maiden name

Josephine Wilson

## 15. Birthplace

Maryland

## 16. Informant

Mrs. Victor Benjamin

## Address

North East, Md.

## 17. (Burial, cremation, or removal. Which?)

Burial Date thereof July 22 1946  
(month) (day) (year)

## Cemetery or crematory

Meth. dist. Cemetery

## Location

North East, Md.

## 18. Funeral director

Joseph B. Grant

## Address

North East, Md.

## 19. Date rec'd by registrar

July 22 1946 Laid V. Crown Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Cecil

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 19 1946 at 9 P M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 1946 to July 19 1946

and that I last saw him alive on July 19 1946

Immediate cause of death myocarditis

## DURATION

Days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

North East, Md. M. D. or other

Address

Date signed

7-22-46

RECEIVED  
JUL 25 1946  
FORWARD A.E.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 931

## CERTIFICATE OF DEATH

06913

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Elkton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 da.  
 Hospital, institution, or street address where death occurred:  
 Union Hospital  
 How long in hospital or institution? 29 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Cecil  
 City or town... Chesapeake City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alatha Borger

## 3. (b) Social Security Number

4. Sex... F  
 5. Color or race... Wh.  
 6.(a) Single, married, widowed, or divorced... Married  
 6.(b) Name of husband or wife... Harry C. Borger  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.)... Sept 4, 1874

8. AGE: Years... 71 Months... 10 Days... 19 If less than one day... hrs. ... min.

8. Birthplace... Delaware City, Del.  
 (Town, county, and state)  
 at home

10. Usual occupation...

11. Industry or business...

12. Name... William Giverson

13. Birthplace... Delaware City, Del

14. Maiden name... Mary Olinck

15. Birthplace... Delaware City, Del

16. Informant... H. J. Borger

Address... Chesapeake City, Md

17. Burial... Date thereof... July 26, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Bethel

Location... New Chesapeake City, Md

18. Funeral director... H. J. Borger

Address... Elkton, Md

19. July 25, 1946

(Date rec'd by registrar) Registrar... FR Fraser

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 23, 1946, at 1:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 32 to July 23, 1946, and that I last saw him alive on July 23, 1946.

Immediate cause of death...

Chronic Myocarditis

Due to...

Ovarian cyst

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... none - Refusal of operation

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Thomas Dorris MD

Address... Chesapeake City, Md

Date signed... 7/23/46

M. D. or other

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF BIRTH

SEX

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NOTED BY CLERK

RECEIVED  
JUL 26 1946  
BUREAU VS



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 06914

Reg. Dist. No. 95

## 1. PLACE OF DEATH

County CecilCity or town Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)Street No. S. Queen Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Amassa Elwood Brown

## 3. (b) Social Security Number

219-07-3319

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Clara E. Brown

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

August 12, 1872

8. AGE:

Years

Months

Days

If less than one day

73731026

hrs.

min.

9. Birthplace

Mount Airy, Pa.

(Town, county, and state)

10. Usual occupation

clerk

11. Industry or business

store

FATHER

12. Name

Theodore H. Brown

13. Birthplace

Pegonia

MOTHER

14. Maiden name

Sara Churchman

15. Birthplace

Calvert, Md.

16. Informant

Clara E. Brown

Address

Rising Sun, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 11, 1946  
(month) (day) (year)

Cemetery or crematory

Brookfield

Location

Rising Sun, Md.

18. Funeral director

Ralph M. Reed

Address

Rising Sun, Md.

19.

(Date rec'd by registrar)

19.

July 10, 1946  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8

19

46 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946 to July 8, 1946and that I last saw him alive on July 8, 1946

Immediate cause of death

Carcinoma of Pancreas

Due to

Due to

Other conditions

Coccyx fracture

(Include pregnancy within 3 months of death)

Major findings of operations

Pancreas

Date of op.

July 46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Dr. B. H. Simpson

M. D. or other

Date signed July 8, 46



DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUL 12 1946  
BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 06915 92

1. PLACE OF DEATH: Cecil  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 116 E High St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Arthur Mitchell Butler  
 3. (b) Social Security Number 218-10-1869

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary Elizabeth Butler  
 7. Birth date of deceased (mo., day, yr.) July 18 1877  
 8. AGE: Years 69 Months 0 Days 8 If less than one day hrs. min.

9. Birthplace North East Cecil Maryland  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Butler  
 13. Birthplace Elkton Md

MOTHER 14. Maiden name Martha Kumble  
 15. Birthplace Elkton. Md

16. Informant Mary E Butler  
 Address Elkton Md

17. Burial Date thereof July 28 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Elkton Cemetery  
 Location Elkton Md

19. Funeral director H W Shipman  
 Address Elkton Maryland

19. July 27 1946  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 12:55 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26 1946, to 1946, and that I last saw him alive on July 26 1946

Immediate cause of death Coronary Thrombosis  
 DURATION 1 hr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Johnson M.D.  
 Address Elkton Md Date signed July 27 1946

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUL 30 1945  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 770

## CERTIFICATE OF DEATH

Reg. Dist. No.

06995

### 1. PLACE OF DEATH

County Cecil  
City or town Rising Sun, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? All life.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Cecil  
City or town Rising Sun, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Wilson, Robert

### 3. (b) Social Security Number

4. Sex M. 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Irma Bailey Calvert  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1912.

8. AGE: 34 Years 4 Months 29 Days If less than one day hrs. min.

9. Birthplace Calera, Cecil Co., Md.  
(Town, county, and state)

10. Usual occupation Stock Dealer & Farmer

11. Industry or business Farmer

12. Name Emma Calvert  
13. Birthplace Cecil Co., Md.

14. Maiden name Mary Little  
15. Birthplace Cecil Co., Md.

16. Informant Mary Calvert  
Address Rising Sun, Md.

17. Burial, cremation, or removal, (Which?) Burial Date thereof July 17, 1946  
(month) (day) (year)

Cemetery or crematory St. Lawrence  
Location Rising Sun, Md. Rural

18. Funeral director J. A. Patterson & Son  
Address Perryville, Md.

19. Date rec'd by registrar July 16, 1946  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-46 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19.

Immediate cause of death Acute Cardiac Failure

Due to

Due to Acute Alcoholism

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE R. L. Dodson, M.D.  
M. D. or other

Address Rising Sun, Md. Date signed 7-15-46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 18 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

06917

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Port Deposit  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:  
Union Hospital Elkton Md

How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Port Deposit  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Lolark

## 3.(b) Social Security Number

4. Sex M. 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 10, 1946.

8. AGE: Years Months Days If less than one day  
4 hrs. min.9. Birthplace Elkton Md.  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business \_\_\_\_\_

12. Name John Lolark

13. Birthplace Port Deposit, Md.

14. Maiden name Blanche Hughes

15. Birthplace Port Deposit Md.

16. Informant Blanche Lolark

Address Port Deposit Md Rural

17. Burial Date thereof July 15, 1946

(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Chesburg Ceme.

Location Port Deposit Md Rural

18. Funeral director Lee A. Patterson &amp; Son

Address Perryville, Md.

19. July 15 1946

(Date rec'd by registrar) Registrar FR Frazer

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1946 at 9:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10 1946 to 7-14 1946

and that I last saw him alive on 1946

Immediate cause of death Premature

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. L. Dodson M.D.

M. D. or other

Address Perryville, Md. Date signed 7-15-46



RECEIVED  
JUL 18 1946  
BUREAU V R



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 06918  
 Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 65 years  
 Hospital, institution, or street address where death occurred:  
E. Main St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. E Main  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emily Evans Constable

## 3. (b) Social Security Number

4. Sex F. 5. Color or race wh. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Judge Albert Constable7. Birth date of deceased (mo., day, yr.) Dec. 29, 1880 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 65 Months 6 Days 18 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Elkton Md  
(Town, county, and state)10. Usual occupation at Home

## 11. Industry or business

12. Name Wm Steel Evans13. Birthplace Rising Sun, Cecil Co. Md14. Maiden name Jane Fraser15. Birthplace Cecil Co. Md16. Informant Mrs Francis Jane KeiferAddress Elkton, Md17. Burial Date thereof July 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ElktonLocation Elkton, Md18. Funeral director H.W. PippinAddress Elkton, Md19. July 19, 1946 JR Fraser  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1946 at 3<sup>50</sup> a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from F.D.T.\_\_\_\_\_ 19 40 to July 17, 1946and that I last saw him alive on July 16, 1946Immediate cause of death Carcinoma of Pancreas

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. Fred R. Sreeder, M.D.Address Elkton, Md Date signed July 17, 1946

RECEIVED

JUL 23 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

## CERTIFICATE OF DEATH

Reg. Dist. No. 06919 95

## 1. PLACE OF DEATH:

County Cecil

City or town Coloma Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Coloma Md Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Henry Ellis Cox Jr.

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.) Sept. 26. 1930

## 8. AGE:

Years

Months

Days

If less than one day

15

9

25

hrs.

mto.

## 9. Birthplace

Rising Sun, Md.  
(Town, county, and state)

## 10. Usual occupation

School Boy

## 11. Industry or business

## FATHER

## 12. Name

Henry Cox

## 13. Birthplace

Va.

## MOTHER

## 14. Maiden name

Elva Graham

## 15. Birthplace

Va.

## 16. Informant

Mr. Theodore Middleton

## Address

Coloma, Md. R. F. D.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

July 24 1946

## Cemetery or crematory

West Nottingham

## Location

Coloma, Ind.

## 18. Funeral director

J. E. Tyson

## Address

Rising Sun

## 19.

(Date rec'd by registrar)

July 23 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 46 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

## Immediate cause of death

Penetrating  
bullet wound of  
left side of chest

## Due to

Internal Hemorrhage

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Coloma Cecil Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury 22 Rifle

Injured at work?

## 23. SIGNATURE

R. L. Dockard

Address: Rising Sun, Md. Date signed 7-21-46

Medical Examiner

for Cecil County

M. D. or other

RECEIVED  
JUL 25 1946  
U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

06920

<b>1. PLACE OF DEATH:</b> County <u>Cecil</u> City or town <u>Veterans Administration, Perry Point, Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 yrs. 6 mo. 15 days</u> Hospital, institution, or street address where death occurred: <u>Veterans Administration, Perry Point, Md.</u> How long in hospital or institution? <u>Same as above</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>119 N. Foundry St.</u> (If rural, give LOCATION) <u>[★]</u> 2. (a) If veteran, name war <u>WW I</u>			
<b>3. (a) FULL NAME</b> <u>EVERLY, John W.</u>				<b>3. (b) Social Security Number</b> <u>214-09-9825</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Mrs. Lurena Everly</u>				<b>6. (c) If alive, give age</b> <u>Unknown</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>December 27, 1898</u>							
<b>8. AGE:</b> Years <u>47</u>		Months <u>6</u>		Days <u>14</u>		If less than one day — hrs. — min.	
<b>9. Birthplace</b> <u>Hagerstown, Md.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Painter</u>							
<b>11. Industry or business</b> <u>—</u>							
<b>12. Name</b> <u>Unknown</u>							
<b>13. Birthplace</b> <u>Unknown</u>							
<b>14. Maiden name</b> <u>Unknown</u>							
<b>15. Birthplace</b> <u>Unknown</u>							
<b>16. Informant</b> <u>Hospital Records</u> Address <u>Veterans Administration, Perry Point, Md.</u>							
<b>17. Removal</b> Date thereof <u>July 12, 1946</u> (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> Location <u>Hagerstown, Md.</u>							
<b>18. Funeral director</b> <u>Pennington &amp; Son</u> Address <u>Pennington &amp; Son, Havre de Grace, Md.</u>							
<b>19. Date rec'd by registrar</b> <u>July 12, 1946</u>							
<b>20. DATE OF DEATH</b> <u>July 11</u> 19 <u>46</u> at <u>2:26 A.</u> M							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>December 26</u> 19 <u>41</u> to <u>DECEMBER 11</u> 19 <u>46</u> and that I last saw him alive on <u>July 11</u> 19 <u>46</u>							
<b>Immediate cause of death</b> <u>Syphilis of the Central Nervous System, Meningo-encephalitic type.</u> Over <u>4</u> yrs.							
<b>Due to</b> <u>—</u>							
<b>Due to</b> <u>—</u>							
<b>Other conditions</b> <u>Psychosis with syphilis of over 4 the central nervous system, Meningo-encephalitic type.</u> Over <u>4</u> yrs.							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b> <u>—</u>							
<b>Autopsy results</b> <u>Same as above</u>							
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b> <u>—</u>							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide. Date of <u>—</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>—</u> Means of injury <u>—</u> Injured at work? <u>—</u>							
<b>23. SIGNATURE</b> <u>A. E. TROLLINGER</u> A. E. TROLLINGER, M.D. Clinical Director Veterans Administration, Perry Point, Md.							

7-11-46

RECEIVED  
JUL 15 1946  
BUREAU V.R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0692194

## 1. PLACE OF DEATH:

County CECIL  
 City or town NORTH EAST  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 YRS  
 Hospital, institution, or street address where death occurred:  
-  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CECIL  
 City or town NORTH EAST  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. -  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war NOT A VETERAN

## 3. (a) FULL NAME

Grant Garrett

## 3. (b) Social Security Number

NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE  
 6. (b) Name of husband or wife -  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) MAY 10 1866  
 8. AGE: Years 80 Months 1 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace North East Rural  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Farmer  
 12. Name C. Halsey Garrett  
 13. Birthplace Penna  
 14. Maiden name Lydia A. McCormick  
 15. Birthplace Penna

16. Informant Kathryn Letts  
 Address North East, Md  
 17. (Burial, cremation, or removal. Which?) Burial Date thereof July 7 1946  
 (month) (day) (year)  
 Cemetery or crematory Methuend  
 Location North East, Md  
 18. Funeral director Joseph R. Shaw  
 Address North East, Md  
 19. July 5- 19 46 Lida B. Lyons  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 46, at 2 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 45, to July 3 19 46,  
 and that I last saw him/her on July 2 19 46.

Immediate cause of death myocarditis DURATION 1 yr.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. B. Collins M. D. Collins  
 Address North East, Md Date signed 7-5-46



RECEIVED  
JUL 9 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-57)

## CERTIFICATE OF DEATH



06922

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Not a patient - An employee  
 Hospital, institution, or street address where death occurred: here since 5-7-46  
 How long in hospital or institution? See above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Anne Arundel  
 City or town... Crownsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... WW I

## 3. (a) FULL NAME

HARDGRAVE, Felix J.

## 3. (b) Social Security Number

4. Sex... Male  
 5. Color or race... White  
 6. (a) Single, married, widowed, or divorced... Married

6. (b) Name of husband or wife... Mrs. Carrie Stubbings

7. Birth date of deceased (mo., day, yr.)... 2-21-1887  
 6. (c) If alive, give age... 42 years

8. AGE: Years... 59 Months... 5 Days... 8 If less than one day... hrs. ... min.

9. Birthplace... Brownsville, Texas  
 (Town, county, and state)

10. Usual occupation... Attendant (Hospital)

11. Industry or business...

12. Name... Felix J. Hardgrave

13. Birthplace... Brownsville, Texas

14. Maiden name... Susan Elizabeth Johnstone

15. Birthplace... Brownsville, Texas

16. Informant... Wife - Mrs. Carrie S. Hardgrave

Address... Crownsville, Md. (State Hospital)

17. Removal... Date thereof... July 29, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Baltimore National Cemetery

Location... Baltimore, Maryland

18. Funeral Director... Pennington &amp; Son

Address... Havre de Grace, Maryland

19. July 29, 1946 James E. Langhans

(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 29, 1946 at 12:37 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sudden death - Pronounced dead above date  
 and that I last saw him alive on and hour

Immediate cause of death... CORONARY ARTERY OCCLUSION... Approx. 30 min.

Due to... ARTERIOSCLEROSIS... Over 5 yrs.

general, coronary and cerebral

Due to...

Other conditions... HYPERTENSION... Over 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op...

Autopsy results... Pulm. Edema - Pleurisy w. effusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Cecil County

M, D, or other

Date signed 7/29-46

REC-5  
JUL 31 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

## CERTIFICATE OF DEATH

06923  
Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
City or town Bainbridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? July 17th to July 29, 1946

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bainbridge, Md.

How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 140 Cathedral Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

## 3. (a) FULL NAME

Alfred Paul Juergens, Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1926

8. AGE: Years 20 Months 6 Days 28 If less than one day hrs. min.

9. Birthplace North East, Cecil County, Md.  
(Town, county, and state)

10. Usual occupation At school

## 11. Industry or business

12. Name Alfred P. Juergens

13. Birthplace Elkton, Maryland

14. Maiden name Florence Boyer

15. Birthplace North East, Maryland

16. Informant Mrs. Florence Juergens

Address Elkton, Maryland

17. Burial Date thereof Aug. 1, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton Catholic Cemetery

Location Elkton, Maryland

18. Funeral director H. W. Pippin &amp; Son

Address Elkton, Maryland

19. July 20 1946 H. W. Pippin & Son  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 July 1946 at 2:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 July 1946 to 29 July 1946

and that I last saw him alive on 29 July 1946

Immediate cause of death Generalized peritonitis, acute

Mesenteric Artery thrombosis

With gangrene of small intestine

Due to Acute gangrenous appendicitis

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results confirmed above diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

H. A. JOHNSON, CDR. (MC) USNR

23. SIGNATURE H. A. JOHNSON, CDR. (MC) USNR

Address U.S. Naval Hospital

Bainbridge, Maryland Date signed 7/30/46

DURATION  
13 days  
3 days  
16 days

RECEIVED  
AUG 1 1945  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
birth date of deceased is  
shown on

FIRM NO. G107-SEPT, 18, 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

06924

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

### 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

### 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19

(Date seen by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

July 29

19

46

at

1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 41

to

July 29

19

46

and that I last saw him alive on

July 28

19

46

Immediate cause of death

Arteriosclerotic Cardis. Vascular

Due to

Coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
AUG 5 1946  
BUREAU V R



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

## CERTIFICATE OF DEATH

06925

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County ElktonCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mass County WorcesterCity or town Worcester  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Samuel Mamoooshian

## 3. (b) Social Security Number

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced6.(b) Name of husband or wife single7. Birth date of deceased (mo., day, yr.) 22 Sept 1923 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 22 Months 9 Days 28 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Worcester, Mass  
(Town, county, and state)10. Usual occupation Brandyman

11. Industry or business

12. Name Srs. Mamoooshian13. Birthplace Armenia14. Maiden name Unknown15. Birthplace Worcester, Mass.16. Informant U.S. Army RecordsAddress Fort Dix N. J.17. Transportation Date thereof July 23, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pittman Funeral HomeLocation 866 Main St., Worcester, Mass.18. Funeral director Howard K. McGowanAddress Abingdon Maryland19. July 25 19 46 JH Trager  
(Date reg'd by registrar) (Year) (Month) (Day) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 46 at 6:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ 10 \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Internal HemorrhageDue to Perforation ofduodenum & left upperDue to lobe of liver 9.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Internal Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7-20-46Where did injury occur? Elkton Cecil Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury 32 Cal. Pistol Injured at work? \_\_\_\_\_Medical Examiner R. L. Woodson23. SIGNATURE Wm. G. Smith County \_\_\_\_\_

M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 7-21-46

RECEIVED

JUL 26 1946

W. F. F. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06926

Reg. Diat. No. 95

## 1. PLACE OF DEATH:

County Cecil  
 City or town Conowingo, R. J. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Cecil  
 City or town Conowingo, R. J. D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lydia Lane Miller

## 3. (b) Social Security Number

220-14-0776

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Hubert Miller  
 6. (c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) Feb. 25 1914  
 8. AGE: Years 32 Months 5 Days 23 if less than one day  
 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Virginia  
 (town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name John W. Keen  
 13. Birthplace Virginia  
 14. Maiden name Allie Jean Boyd  
 15. Birthplace Virginia

16. Informant Hubert Miller  
 Address Conowingo, Md. R. J. D.  
 17. Burial Date thereof June 21 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist  
 Location Conowingo, Md.

18. Funeral director F. E. Tyson  
 Address Rising Sun, Md.

19. July 21 1946 L. M. Montgomery  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1946 at 11 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1946 to July 18 1946  
 and that I last saw him June 18 1946 alive on July 18 1946  
 Immediate cause of death \_\_\_\_\_

Duration 15 mo.  
 Due to Hepatic Carcinoma  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
 Major findings of operations Hepatic Carcinoma  
 Date of op. June 18  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other  
[Signature] Date signed July 19 1946  
 Address \_\_\_\_\_

RECEIVED  
JUL 22 1946  
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(22-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

06927

## 1. PLACE OF DEATH:

County Beele  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? since 1897  
 Hospital, institution, or street address where death occurred:  
in hosp.  
 How long in hospital or institution? about 10 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Beele  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1028 Main St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Emma Albertina Minster

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife John Jacob Minster  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Nov 9 - 1867  
 8. AGE: Years 78 Months 8 Days 21 If less than one day  
 ..... hrs. .... min.

9. Birthplace Germany10. Usual occupation Housewife

11. Industry or business

12. Name Albert Schwartz13. Birthplace Germany14. Maiden name unknown15. Birthplace Germany16. Informant Miss Lillian MinsterAddress Elkton - Md17. Burial Date thereof Aug 1 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Elkton CemeteryLocation Elkton Md18. Funeral director N. W. P. ...Address Elkton. Md19. July 31 19 46(Date recd by registrar) Registrar J. H. Frazer

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 46 at 1.05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 27 19 46 to July 30 19 46and that I last saw him/her alive on July 30 19 46Immediate cause of death Myocardial infarction froma rupture of left ventricleDue to late as 2ndpericardial effusion of left sideDue to strangulated

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. McKnight M.D.Address Elkton - MdDate signed July 30 - 46

M. D. or other

RECEIVED BY BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED  
AUG 2 1946  
BUREAU OF INVESTIGATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County... Cecil  
 City or town... Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs. 6 days  
 Hospital, institution, or street address where death occurred:  
 Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? SAME AS ABOVE

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 1612 Poplar Grove Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... WW I

## 3. (a) FULL NAME

PEPPLER, Harry E.

## 3. (b) Social Security Number

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Separated  
 6. (b) Name of husband or wife... Emily B. Peppler  
 6. (c) If alive, give age... Unknown years  
 7. Birth date of deceased (mo., day, yr.)... February 16, 1882  
 8. AGE: Years... 64 Months... 4 Days... 23 If less than one day... hrs. min.

9. Birthplace... Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation... Cook  
 11. Industry or business...  
 12. Name... Unknown  
 13. Birthplace... Unknown  
 14. Maiden name... Unknown  
 15. Birthplace... Unknown

16. Informant... Hospital Records  
 Address... Veterans Administration, Perry Point, Md.  
 17. Removal... Date thereof... 7-12-1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Baltimore National Cemetery  
 Location... Baltimore, Maryland.  
 18. Funeral director... Pennington & Son  
 Address... Havre de Grace, Md.

19. July 12, 1946 June E. Dougherty  
 (Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 9, 1946, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1946, to July 9, 1946, and that I last saw him alive on July 9, 1946.

Immediate cause of death... Cerebral Thrombosis DURATION... 3 days

Due to Cerebral arteriosclerosis over 3 yrs.  
 Myocardial Insufficiency over 2 yrs.  
 Due to Myocardial damage over 2 yrs.

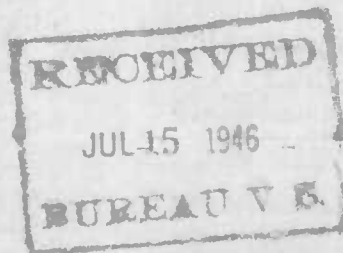
Other conditions... Psychosis with cerebral arteriosclerosis over 2 yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations... Same as above  
 Date of op. ...

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury... Injured at work?

23. SIGNATURE... E. TROLLINGER, M.D., Clinical Director  
 Address... Veterans Administration, Perry Point, Md. 7-11-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of wife of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of name **MARYLAND STATE DEPARTMENT OF HEALTH**  
of wife of deceased is shown on 2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

FILM No. I O 6 AUG 26 1946

Reg. Dist. No. 06929 94

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lewis N. Phillips

## 3. (b) Social Security Number

none

4. Sex.....

M.

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced.....

Married.

6. (b) Name of husband or wife.....

Anna

Jenna R. Phillips

7. Birth date of deceased (mo., day, yr.).....

Sept 14 1869

8. (c) If alive, give age.....

73 years

8. AGE:

Years

Months

Days

If less than one day

76

10

7

hrs.

min.

9. Birthplace.....

Maryland.

(Town, county, and state)

10. Usual occupation.....

Retired Trade Foreman

11. Industry or business.....

MOTHER / FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. Which?).....

Date thereof.....

7-24-46

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Late rec'd by registrar).....

19. 46

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

7-21

19. 46 at 540P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-20

19. 46

to

7-21

19. 46

and that I last saw him alive on

7/20

19. 46

Immediate cause of death.....

Leucosarcoma of liver.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

M. D. or other

Date signed 7-23-46

RECEIVED  
JUL 27 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 80-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 Hollingsworth Manor  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW II

## 3. (a) FULL NAME

ROWLAND, Elmer

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife JEANETTE ROWLAND  
 7. Birth date of deceased (mo., day, yr.) 2-2-1909 6. (c) If alive, give age 22 years

8. AGE: Years 37 Months 5 Days 9 If less than one day  
 hrs. min.

9. Birthplace Chilhowis, Smyth Co. Va.  
 (Town, county, and state)

10. Usual occupation Hospital Attendant

11. Industry or business

FATHER 12. Name David Rowland  
 13. Birthplace Ashe County, N.C.  
 MOTHER 14. Maiden name Elizabeth Brown  
 15. Birthplace Ashe County, N.C.

16. Informant Hospital Records  
 Address Veterans Administration, Perry Point, Md.

17. Removal July 12, 1946 Date thereof (month) (day) (year)  
 (Burial, cremation, or removal. Which?)

Cemetery or crematory Mt. Carmel Cemetery  
 Location Marion, Virginia

18. Funeral director Pennington & Son  
 Address Havre de Grace, Md.

19. July 12 19 46 Date rec'd by registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 46 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 19 46 to July 11 19 46 and that I last saw him alive on July 11 19 46

Immediate cause of death Abscess of brain Duration undetermined

Due to

Due to

Other conditions Hemiplegia, left arm and leg 17 days  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

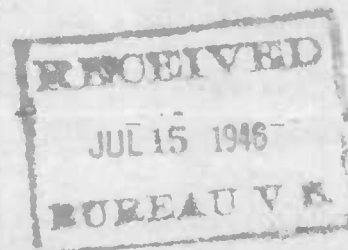
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Hollingsworth Clinical Director  
E. Hollingsworth Registrar  
 Address Veterans Administration, Perry Point, Md. Date signed July 12, 1946





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-a

06931

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County Cecil

City or town Cecil  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Cecil  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Ruly

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

Caucas

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 30 1946

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

July 30 1946

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## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1946 to July 26 1946

and that I last saw him alive on July 26 1946

## Immediate cause of death

1. Acute myocardial infarction

2. Arteriosclerosis

3. Cardiac arrhythmia

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

## Address

M. D. or other

Date signed 7/29/46

RECEIVED

AUG 5 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

06932

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County... Cecil, Susquehannah River  
 City or town... Perryville, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Walking Bridge  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Havre De Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 856 Ontario  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Leland S Sharp

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife M. Olive Jackson Sharp

7. Birth date of deceased (mo., day, yr.) April 20, 1903 6. (c) If alive, give age years

8. AGE: Years 43 Months 2 Days 27 If less than one day hrs. min.

9. Birthplace Trappe, Talbot Co., Md.  
 (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Penna. R.R.

12. Name George W. Sharp

13. Birthplace Michigan

14. Maiden name Emily E. Seymour

15. Birthplace Trappe, Md

16. Informant M. Olive S Sharp

Address 856 Ontario St., Havre De Grace, Md.

17. Burial Date thereof Aug. 1, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre De Grace, Md.

18. Funeral director Lee J. Patterson

Address Perryville, Md.

19. Aug. 1, 46 James E. Dougherty  
 (Date reg. by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17 1946 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Drowned

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Perryville, Md. (City or town) (County) (State)

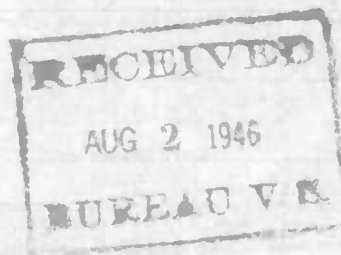
Injured at home, farm, industry, public place (where?) Susquehanna River

Means of injury Fall off R.R. Bridge Injured at work? From bridge

23. SIGNATURE P. L. Rockwell M.D. Medical Examiner

Address P. L. Rockwell M.D. Harford County

Date signed 7/30-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours  
 Hospital, institution, or street address where death occurred:  
Baltimore General Hospital  
 How long in hospital or institution? 6 hours 20 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Lancaster  
 City or town Lancaster  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 148 Franklin St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Stumpf

## 3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bora B. Meyers Stumpf

7. Birth date of deceased (mo., day, yr.) Feb. 20 1884  
 8. (c) If alive, give age 60 years

8. AGE: Years 62 Months 4 Days 25 It less than one day  
 hrs. min.

9. Birthplace Lancaster Pa.  
 (Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

12. Name Jaeyb Stumpf  
 13. Birthplace Germany

14. Maiden name Margaret Bombberger  
 15. Birthplace Lancaster Pa.

16. Informant R. E. Boyer  
 Address 318 N. Duke St. Lancaster Pa.

17. REMOVAL Date thereof 7/16/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GREENOAK MEMORIAL PARK

Location LANCASTER, PA  
William J. Robinson

18. Funeral director WILLIAM J. ROBINSON  
 Address LANCASTER, PA

19. Date rec'd by registrar July 16 1946  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1946 at 9:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...  
 and that I last saw him... alive on 19...

Immediate cause of death

Cerebral Hemorrhage  
 Due to...  
 Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Robinson Medical Examiner

M. D. or other

Date signed 7-16-46

RECEIVED  
JUL 18 1946  
BUREAU OF V. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH  
age of deceased is shown on 2411 N. Charles St., Baltimore 30

06934

FILM No. I 06 JUL 17 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hosp.

206 CATHEDRAL street

How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Cecil

City or town Elk Neck - R.D. 1  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Hilda C. Swanson

## 3. (b) Social Security Number

217-12-5320

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white MARRIED

6. (b) Name of husband or wife Charles A. Swanson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1917

8. AGE: Years Months Days If less than one day  
28 11 29 0 22 hrs. min.8. Birthplace CALM, NORTH DAKOTA  
(Town, county, and state)

10. Usual occupation housewife

## 11. Industry or business

12. Name Rudolph Rist

13. Birthplace Russia

14. Maiden name Lydia Zhaon

15. Birthplace Raleigh N C

16. Informant Charles A Swanson

Address Elkton Md R D 1

17. Burial Date thereof July 9 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory North East Cemetery

Location North East Maryland

18. Funeral director J. W. Zinn

Address Elkton Md

19. July 8 1946

(Date rec'd by registrar)

Registrar J. B. Frazer

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 July 1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 July 1946 to 6 July 1946

and that I last saw her alive on 6 July 1946

Immediate cause of death Encephalitis, acute

DUE TO Cerebrospinal Syphilis

DURATION 10 days

DUE TO 3 years

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Klaus H. Fischer M.D.

Address North East Maryland Date signed 6 July '46



RECEIVED

JUL 9 1946

BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

06935  
Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? June 15/46 - July 5/46  
 Hospital, institution, or street address where death occurred:  
Union Hospital  
 How long in hospital or institution? 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town Chesapeake City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Carrie Simpson Thornton

## 3.(b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife George N Thornton  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Feb'y 14 1878  
 8. AGE: Years 68 Months 4 Days 21 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md  
 (Town, county, and state)  
 10. Usual occupation at home

## 11. Industry or business

MOTHER FATHER  
 12. Name Charles Simpson  
 13. Birthplace Baltimore Md  
 14. Maiden name Martha White  
 15. Birthplace Baltimore Md

16. Informant Norwood Thornton  
 Address West Grove Pa

17. Burial Date thereof July 8 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel  
 Location Chesapeake City Md R.D.

18. Funeral director H. W. Phipps  
 Address Elkton Md

19. July 8 1946  
 (Date rec'd by registrar) JK Frazer Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1946 at 9:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1946 to July 5 1946 and that I last saw him alive on July 5 1946  
 Immediate cause of death Apoplexy

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos D. ...  
 Address Chesapeake City Md Date signed 7/6/46

CERTIFICATE OF DEATH

RECEIVED

JUL 9 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06936

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 mo. 15 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County —  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 412 N. Carrollton Avenue  
 (If rural, give LOCATION)  
 2. (a) Is veteran, name war WW I

## 3. (a) FULL NAME

TURNER, Samuel

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife XXXXXXXX Marie Brown  
 6. (c) If alive, give age 40 years  
 7. Birth date of deceased (mo., day, yr.) May 17, 1894  
 8. AGE: Years 52 Months 2 Days 6 It less than one day — hrs. — min.

9. Birthplace Balto., Md.  
 (Town, county, and state)  
 10. Usual occupation —  
 11. Industry or business —  
 12. Name John Turner  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Annie Page  
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records  
 Address Veterans Administration, Perry Point, Md.  
 17. Removal Date thereof July 23, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Md.

18. Funeral director Mrs. Katie Williams, 322 N. Schroeder  
 Address Street, Baltimore, Md.

19. July 23 19 46 Dr. E. H. Hargrave  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 19 46 at 9:25A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 8, 1946 19 46 to July 23 19 46  
 and that I last saw him alive on July 23 19 46

Immediate cause of death Pneumonia, bronchial DURATION 5 days

Due to —Due to —Other conditions Psychosis undiagnosed Duration 4 mo.

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results Not performed.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

23. SIGNATURE E. H. Hargrave M. D. or other —  
 Administration, Perry Point, Md. Date signed 7-23-46

RECEIVED  
JUL 25 1946  
RECEIVED

W. J. Beckwith

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 96

06937

## 1. PLACE OF DEATH:

County Cecil  
 City or town Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 6 mo. 22 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Mass. County Worcester

City or town Dorchester  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Bispham St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war Peacetime

## 3. (a) FULL NAME

WICHUNES, Bronislaw

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age. - years

## 7. Birth date of deceased (mo., day, yr.)

December 25, 1914

## 8. AGE:

Years

Months

Days

If less than one day

31628- hrs.- min.

## 9. Birthplace

New Bedford, Mass.

(Town, county, and state)

## 10. Usual occupation

Mechanic

## 11. Industry or business

-FATHER  
MOTHER

## 12. Name

Joseph Wajcium

## 13. Birthplace

Lithuania

## 14. Maiden name

Elizabeth Kushlieka

## 15. Birthplace

Lithuania

## 16. Informant

Hospital Records

## Address

Veterans Administration, Perry Point, Md.

## 17.

Removal

Date thereof

7-26-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Arlington National Cemetery

## Location

Ft. Myer, Va.

## 18. Funeral director

## Address

Pennington & Son, Barré de Grace, Md.

## 19.

July 26, 1946  
(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1946 at 11:50A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 31, 1943 to July 23, 1946  
 and that I last saw him alive on July 23, 1946

Immediate cause of death Multiple Sclerosis Over 8 years

Due to

Due to

Other conditions Psychosis with Multiple Sclerosis 3 years  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

A.E. TROLLINGER, M.D. Acting Manager other

Veterans Administration Date signed 7-23-46Perry Point, Md.

RECEIVED  
JUL 29 1946  
BUREAU V S